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Attorneys for Defendants
The Regents of the University of California and
Michael V. Drake

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF ALAMEDA

CINDY KIEL, J.D., an Executive Associate Vice Chancellor at UC Davis, MCKENNA HENDRICKS, a UC Santa Barbara student, EDGAR DE GRACIA, a UCLA student, and LELAND VANDERPOEL, an employee at the Fresno satellite extension of the UCSF Medical Education Program, and FRANCES OLSEN, Professor of Law at UCLA,

Plaintiff,

v.

THE REGENTS OF THE UNIVERSITY OF CALIFORNIA, a Corporation, and MICHAEL V. DRAKE, in his official capacity as President of the UNIVERSITY OF CALIFORNIA,

Defendants.

Case No. HG20072843

Unlimited Civil Jurisdiction

ASSIGNED FOR ALL PURPOSES TO:
Hon. Richard L. Seabolt
Department 521

DECLARATION OF DR. ARTHUR L. REINGOLD, M.D. IN SUPPORT OF DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Date: October 14, 2020
Time: 01:30 p.m.
Dept.: 521
Reservation No.: 2206283

Complaint filed: August 27, 2020
Trial: None set

I, Arthur L. Reingold, M.D., declare:

1. I provide this declaration in support of Defendants The Regents of the University of California and Michael V. Drake's ("Defendants") Opposition to Plaintiffs' Motion for Preliminary Injunction. I base this declaration on my expertise as outlined below and facts within my personal knowledge, to which I could and would testify competently if called upon to do so.

2. I am the Division Head of Epidemiology at the University of California, Berkeley, School of Public Health. I have worked on the prevention and control of infectious diseases in both the United States, including eight years at the U.S. Centers for Disease Control and Prevention ("CDC"), and with numerous developing countries around the world for over forty years. Since its inception in 1994, I have directed or co-directed the CDC-funded California Emerging Infections Program. I am a member of the Society for Epidemiologic Research and the American Epidemiological Society; an elected Fellow of the Infectious Disease Society of America and of the American Association for the Advancement of Science; and an elected member of the Institute of Medicine of the National Academy of Sciences. I was previously the President of both the Society for Epidemiologic Research and the American Epidemiological Society. I have served on the editorial boards of the following journals: American Journal of Epidemiology, Epidemiology, and Global Public Health. I am also currently an Associate Editor of the journal, Vaccine.

3. I received my A.B. in biology from the University of Chicago in 1970, and my M.D. from the University of Chicago in 1976. Among other things, I completed a residency in internal medicine and a preventive medicine residency with the CDC.

4. My career in public health has been in the area of infectious diseases and epidemiology. Following my positions at the CDC (1979–1987), I joined the faculty of the School of Public Health at Berkeley as a Professor of Epidemiology (1987–present), the faculty of the Department of Epidemiology and Biostatistics at the University of California, San Francisco ("UCSF") (1989–present), and as a Clinical Professor in the Department of Medicine at UCSF (1991–present). From 1990–1994, I was the Head of the Epidemiology Program, Department of Biomedical and Environmental Health Sciences, University of California,

Berkeley; from 1994–2000, I was the Head of the Division of Public Health Biology and Epidemiology, University of California, Berkeley. Since 2000, I have been Head of the Division of Epidemiology, School of Public Health, University of California, Berkeley.

5. My research focuses on emerging and re-emerging infections in the United States and in developing countries; respiratory infections and vaccine-preventable diseases in the United States and in developing countries, including influenza and, since it emerged in 2020, COVID-19; and disease surveillance, outbreak detection, and outbreak response.

6. Attached hereto as **Exhibit A** and incorporated by reference to this declaration is a copy of my curriculum vitae.

Background on COVID-19

7. I am currently involved in multiple projects related to SARS-CoV-2, a novel coronavirus that causes Coronavirus Disease 2019 (COVID-19). I am collaborating on research concerning SARS-CoV-2 and its incidence, and serving on SARS-CoV-2 advisory groups for multiple organizations, including UC Berkeley, the University of California system, and the City and County of San Francisco, among others. I have recently served on two COVID-related committees for the National Academy of Science, Engineering, and Medicine: I helped organize and moderate a two-day workshop on the Role of Aerosols in Transmitting SARS-CoV-2, and I worked as a member of the committee on the Equitable Distribution of COVID-19 Vaccines in the U.S.

8. As of September 27, 2020, there were over 7.1 million confirmed cases of COVID-19 in the United States, and over 204,000 confirmed deaths caused by the virus.[1] Nationally, the number of confirmed cases has increased dramatically since the pandemic began in early 2020. In California alone, there are approximately 800,000 confirmed cases and over 15,000 deaths.[2]

9. Importantly, the rise in cases is not just a reflection of increased testing. If the rate of COVID-19 were stable or decreasing, increased testing would produce a lower proportion of

[1] Johns Hopkins, "Coronavirus Resource Center," available at https://coronavirus.jhu.edu/us-map (last accessed Sept. 25, 2020).
[2] *Id.* at https://coronavirus.jhu.edu/region/us/california (last accessed Sept. 25, 2020).

tests being positive, as presumably, a larger and more representative selection of the population (not only those with symptoms or known exposure) would be included. Since the case rate and the proportion of tests positive rate have increased simultaneously, data suggest that the increase in confirmed cases indicates a true rise in cases, as do the numbers and rates of COVID-19 hospitalizations and deaths.[3]

10. SARS-CoV-2 virus is a respiratory virus; COVID-19 patients typically, but not invariably, present with acute respiratory signs and symptoms. The most common symptoms are fever, cough, and shortness of breath. Other identified symptoms include muscle aches, headaches, chest pain, diarrhea, coughing up blood, sputum production, runny nose, nausea, vomiting, sore throat, confusion, loss of senses of taste and smell, and loss of appetite. Due to the respiratory impacts of the disease, individuals may need to be put on oxygen, and in severe cases, patients may need to be intubated and put on a ventilator. COVID-19 can lead to respiratory failure, other organ failure, and/or other serious, life-threatening complications, such as cardiovascular events, strokes, and seizures. Strokes have been reported in people in their thirties. COVID-19 cases in children, while less frequent, can be severe, even fatal. COVID-19 is also known to impact the brain and nervous system.

11. Pandemics like the current one occur when the number of infections grows exponentially. Fixed rate exponential growth means that the number of infections doubles in a defined amount of time. For example, if on day one of the outbreak there are 100 infected individuals and the doubling period is five days, by day six (five days later) 200 individuals will have become infected, and by day 11 (five days later) 400 individuals will have become infected. By contrast, linear growth would mean a steady increase in infections per a given period of time (*e.g.*, 100 new infections every five days). The shorter the doubling time, the greater the growth rate of the epidemic/pandemic. If exponential growth rates are not moderated, the number of infections and resultant illnesses can quickly overwhelm a given health system. The term "flattening the curve" refers to attempts to lengthen the doubling period of infections and thereby

[3] New York Times, "Covid in the U.S.: Latest Map and Case Count," available at https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html (last accessed Sept. 27, 2020).

prevent a collapse of the healthcare system. Reducing the growth rate of infections and resultant disease is achieved through both official policies and changes to individual social behavior.

12. Many models indicate that SARS-CoV-2 infections and cases of COVID-19 will persist through the end of 2020 and into 2021.[4] Their persistence (and indeed surge) during the summer months only underscores the likelihood that SARS-CoV-2 and COVID-19 cases will be present in the U.S. throughout the time period coinciding with the upcoming influenza season. Currently, there is no cure for COVID-19 nor any foolproof means of preventing its spread, short of complete isolation.

13. There is not yet an FDA-approved vaccine against SARS-CoV-2 that could be used to immunize the population against the virus. Most experts do not expect widespread availability of a COVID-19 vaccine until 2021, at the earliest. Dr. Fauci of the National Institutes of Health (NIH) has recently stated that it is possible a vaccine may be ready as early as the end of 2020. However, it would take significantly more time before substantial numbers of doses of the vaccine become readily available and can be delivered to the public at large. In no currently foreseeable circumstances is an effective vaccine anticipated to be broadly distributed before the upcoming influenza season in the U.S.

14. Due to the ease of transmission, the high risk to certain parts of the population, and the fact that SARS-CoV-2 will continue to spread unless and until widespread vaccination and/or herd immunity is achieved, individuals will need to continue to take steps to prevent infection and reduce the burden on healthcare delivery systems.

Safety and Efficacy of Influenza Vaccine

15. There are reasons to believe that the continued COVID-19 pandemic may have an even more severe impact during the fall of 2020 and winter of 2020-2021 because of the

[4] Kristine A. Moore, Marc Lipsitch et al., "COVID-19: The CIDRAP Viewpoint," CIDRAP (April 30, 2020): https://www.cidrap.umn.edu/sites/default/files/public/downloads/cidrap-covid19-viewpoint-part1_0.pdf (concluding based on lessons from previous influenza pandemics that in a best case scenario, COVID-19 would continue for 18 months, which from time of publication would be October 2021); Ryan Best and Jay Boice, "Where The Latest COVID-19 Models Think We're Headed -- And Why They Disagree," FiveThirtyEight (August 6, 2020): https://projects.fivethirtyeight.com/covid-forecasts/ (comparing 15 models published by scientists to illustrate possible trajectories of the pandemic's death toll, all of which show increases in COVID-19 deaths through at least September 2020).

overlapping effects of influenza (flu). Influenza is a respiratory virus that peaks seasonally in the fall and winter, and produces many of the same symptoms as COVID-19. The COVID-19 pandemic arrived in the U.S. as the 2019-2020 influenza season was coming to an end. As a result, no region of the U.S. has yet experienced co-circulation of the SARS-CoV-2 virus and various influenza viruses, so there is no evidence one way or another concerning what might happen if an individual were to become infected with both viruses at the same time. However, both influenza and SARS-CoV-2 cause severe, life-threatening infections of the respiratory tract and related complications, hospitalizations, intensive care unit admissions, need for intubation, and death, and both of them are particularly severe in the elderly and those with various underlying medical conditions. As colder weather forces more people to be indoors and with both viruses expecting to be in widespread circulation in the U.S. this winter, it is highly likely that the dual impact on hospitals and the healthcare system in general will be substantial, quite possibly exceeding the impact of either disease alone, and in the absence of a widely available effective and safe COVID-19 vaccine, influenza vaccine and vaccination will be a very important tool for minimizing the burden on the healthcare system and also minimizing illnesses, hospitalizations, and deaths due to respiratory infections. Moreover, if all these viral infections occur at the same time, it will be more difficult to determine whether symptoms are indicative of COVID-19 or influenza virus infection in individual patients and the population more broadly.

16. Influenza is caused by infection with the influenza virus, including various strains of influenza A and influenza B. The specific strains that circulate in the human population vary from year to year. The influenza virus is readily transmitted from person to person via respiratory secretions produced by coughing and sneezing, with the infections showing marked seasonality in temperate countries like the U.S., such that influenza occurs only in the late fall, winter, and early spring (hence "flu season"), although the timing of the beginning and end of influenza season can vary substantially from one year to the next. While infection with and transmission of influenza virus are most common among children, it is the very young, the very old, and those with a variety of underlying medical conditions (*e.g.* cardiovascular disease, pulmonary disease, etc.) who are most likely to develop severe influenza and its complications and to be hospitalized and

to die of the disease as a result.[5]

17. Beyond pneumonia and related infections and deaths due to respiratory tract infections, influenza has been shown to cause a substantial increase in the risk of strokes, heart attacks, worsening congestive heart failure, and other adverse health outcomes, leading to substantial morbidity, hospitalization, healthcare costs, and deaths beyond what is directly attributable to influenza infections of the respiratory tract. While the burden of illness, hospitalization, and death due to influenza varies from year to year, the CDC has estimated that during the 2017-2018 influenza season, influenza caused 45 million illnesses, 810,000 hospitalizations, and 61,000 deaths in the U.S. alone.[6] In the absence of influenza vaccination, even with only 40% of the U.S. population choosing to be vaccinated that year and the vaccine being only partially protective, the CDC has estimated that an additional 6.2 million illnesses, 91,000 hospitalizations, and 5,700 deaths would have occurred during the 2017-2018 influenza season in the U.S.

18. Because the influenza virus changes very rapidly, and no universal influenza vaccine yet exists, influenza vaccine has to be formulated and given annually, based on the best available evidence concerning which strains of influenza A and B virus will be circulating in the upcoming influenza season. While most doses of influenza vaccine given in the U.S. each year are inactivated (*i.e.* killed), a live attenuated form of the vaccine is also available for use in certain populations, as are higher potency vaccines that are recommended for use in the elderly. Based on extensive studies and evidence concerning the burden of influenza-related morbidity and mortality, as well as healthcare costs and other costs to society, and on the extensive evidence that influenza vaccines are very safe, the Advisory Committee on Immunization Practices (ACIP) of the U.S. CDC, the U.S. Preventive Services Task Force, and many clinical organizations'

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[5] *See, e.g.*, Panhwar, Muhammad S., "Effect of Influenza on Outcomes in Patients With Heart Failure," *JACC: Heart Failure*, 2019 Feb., 7(2) (Jan. 2, 2019); Ciszewski, Andrzej, "Cardioprotective effect of influenza and pneumococcal vaccination in patients with cardiovascular diseases," *Vaccine* (Jan. 4, 2018).

[6] CDC, "2017-2018 Flu Season: Burden and Burden Averted by Vaccination," available at https://www.cdc.gov/flu/about/burden-averted/2017-2018.htm (last accessed Sept. 27, 2020); *see also* Rolfes, Melissa A., *et al.*, "Effects of Influenza Vaccination in the United States During the 2017-2018 Influenza Season," *Clinical Infectious Diseases* (Feb. 2, 2019).

advisory groups recommend annual influenza immunization of everyone old enough to receive the vaccine, including pregnant women.

19. Many millions of doses of influenza vaccine have been given to children, adults, the elderly, and pregnant women over the past more than 60 years, and numerous carefully done epidemiological studies have shown that influenza vaccine and vaccination in all of these groups has an excellent safety profile. Moreover, not only is the influenza vaccine safe for pregnant women, health experts recommend that pregnant women receive the influenza vaccine to protect them from the risk of influenza-associated acute respiratory infection.[7] Vaccination of pregnant women is seen as important both to protect the pregnant woman herself, because influenza during pregnancy can threaten the life of the woman and the fetus, and to protect the newborn baby prior to the age at which the baby can be vaccinated.[8] A recent study showed that the influenza vaccine reduced a pregnant woman's risk of being hospitalized with influenza by an average of 40 percent.[9] In sum, the influenza vaccine is safe for the UC population of students, faculty, and staff affected by the Executive Order at issue in this case.

20. The scientific and public health consensus is that the influenza vaccine is effective in preventing illnesses, hospitalizations, and deaths caused by influenza virus.[10] Vaccine effectiveness can vary by season, influenza virus strain in the vaccine, age of the recipient, the presence of underlying medical conditions, and other factors. While influenza vaccines are typically less effective than many of the other vaccines routinely given in the U.S., they are the

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[7] Kim, Sara S., *et al.*, "Effects of Prior Season Vaccination on Current Season Vaccine Effectiveness in the United States Flu Vaccine Effectiveness Network, 2012-2013 Through 2017-2018," *Clinical Infectious Diseases* (June 1, 2020).

[8] Foo, Damien Y.P., *et al.*, "Early Childhood Health Outcomes Following In Utero Exposure to Influenza Vaccines: A Systematic Review," *Pediatrics*, Vol. 146 2 (Aug. 2020); Munoz, Flor M. and Long, Sarah S., "The Safety of Maternal Influenza Vaccination and Infant Health Outcomes," *Pediatrics* Vol. 146 (July 27, 2020); Thompson, Mark G., *et al.*, "Influenza Vaccine Effectiveness in Preventing Influenza-associated Hospitalizations During Pregnancy: A Multi-country Retrospective Test Negative Design Study, 2010-2016," *Clinical Infectious Diseases* (Oct. 11, 2018).

[9] Thompson, Mark G., "Influenza Vaccine Effectiveness in Preventing Influenza-associated Hospitalizations During Pregnancy: A Multi-country Retrospective Test Negative Design Study, 2010-2016," *Clinical Infectious Diseases*, available at https://academic.oup.com/cid/article/68/9/1444/5126390 (last accessed Sept. 26, 2020).

[10] Thompson, Mark G., *et al.*, "Influenza vaccine effectiveness in preventing influenza-associated intensive care admissions and attenuating severe disease among adults in New Zealand 2012-2015," *Vaccine*, Vol. 36, Issue 39 (Sept. 18, 2018).

most effective tool available for reducing the number of influenza illnesses, hospitalizations and deaths each year. In the 2018-2019 influenza season, the influenza vaccine prevented an estimated 4.4 million influenza illnesses, 2.3 million influenza-associated medical visits, 58,000 influenza-associated hospitalizations, and 3,500 influenza-associated deaths.[11] Importantly, even in years when the vaccine has relatively low effectiveness, influenza vaccines are effective in reducing severity and morbidity from influenza. The utility of influenza vaccines generally can be inferred from the recommendations for the widespread vaccination of people throughout the medical profession for decades at both the state and federal level.

21. Hesitancy to routine influenza vaccination lacks a basis in the science and is often based on misinformation or lack of information. However, despite the existence of vaccine hesitancy more broadly, the vast majority of the population understands that the potential risks posed by influenza vaccination are rare and outweighed by the significant benefits of reducing influenza-related complications, hospitalizations, and deaths. Critically, contrary to Plaintiffs' and Plaintiffs' declarants' assertions, the fact that not everyone gets an influenza shot on a regular basis is not evidence of vaccine hesitancy or legitimate and founded public skepticism over efficacy. Rather, other variables such as adequate access to preventative healthcare in the U.S. account for the discrepancy between the number of people who should receive the influenza vaccine and those who do.

The Executive Order Mandating Influenza Vaccine

22. I support the University's influenza vaccine mandate as an important public health measure for protecting the health and safety of students, faculty, and staff on UC campuses. There is no question from a medical and public health standpoint that anything that can be done to reduce the impact of influenza illness on hospitals and healthcare workers can mitigate the impact of COVID-19 on these institutions and healthcare workers. Other measures, such as social distancing accomplished in part by UC's policy to move its curriculum to primarily remote

[11] CDC, "Vaccine Effectiveness: How Well Do the Flu Vaccines Work?," available at https://www.cdc.gov/flu/vaccines-work/vaccineeffect.htm (last accessed Sept. 26, 2020); *see also* Chung, Jessie R., *et al.*, "Effects of Influenza Vaccination in the United States During the 2018-2019 Influenza Season," *Clinical Infectious Diseases* (Jan. 6, 2020).

instruction and the mandated use of masks on campus, are also good precautionary measures. But each of these measures is imperfect and cannot, alone, prevent the effects of the COVID-19 pandemic from becoming worse. The best advice by experts is that these measures should be overlapping and used in concert.

23. From an epidemiological perspective, it is virtually certain that there will be COVID-19 and influenza circulating simultaneously this winter. The fact that influenza seasons are not as bad in some years tells us nothing about what to expect in the approaching influenza season. Because we do not know what influenza virus strains will be circulating or their properties, how pathogenic they will be, or what the morbidity/mortality will be this year, it is incumbent on public health officials to mitigate the effects of influenza, including ensuring that there is widespread influenza vaccination.

24. I have reviewed the declarations of Plaintiffs' declarants, Peter Gotzsche, M.D., Peter Doshi, Ph.D., Tom Jefferson, M.D., Laszlo Boros., M.D., and Andrew Noymer, Ph.D. Several of their opinions stand out as being particularly misleading and contrary to the weight of scientific authority. *First*, there is no support in any serious peer-reviewed scientific journal to support the opinion that the influenza vaccine is unsafe or ineffective. All the preeminent clinical and pubic health experts in the world agree that the influenza vaccine is safe and reasonably effective, notwithstanding the fact that the influenza vaccine is more effective in some years than in others. Similarly, the medical and public health consensus is that, in any given year, the use of the influenza vaccine prevents large numbers of avoidable infections, hospitalizations, and deaths. *Second*, Plaintiffs overstate the ineffectiveness of the influenza vaccine amongst seniors, overstate the safety risks to seniors, and ignore the fact that the UC target population overwhelmingly consists of individuals under the age of 65. *Third*, Plaintiffs and the declarants' opinions regarding safety and efficacy of the influenza vaccination for pregnant women are contrary to the best medical and public health advice. In fact, as discussed above, pregnant women should receive the influenza vaccine to protect themselves and the fetus and eventually the newborn baby through the age of six months. As with adults over age 65, the number of pregnant women on a university campus is also exceedingly low. And *fourth*, to the extent that Plaintiffs and the

declarants opine that the influenza vaccine does not directly prevent COVID-19, that point is not controversial, as a vaccine is generally only effective against the target virus; however, Plaintiffs and Plaintiffs' declarants ignore the larger point that reducing the impact of an influenza outbreak will assist public health officials in combatting the effects of the COVID-19 pandemic by preventing symptom confusion and alleviating the strain on healthcare systems and supplies.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct to the best of my knowledge.

Executed in Bakersfield, California, on this 29th day of September 2020.

Arthur L. Reingold, M.D.

EXHIBIT A

August, 2020

CURRICULUM VITA

Arthur Lawrence Reingold

PRESENT POSITION: Professor of Epidemiology
Division Head, Epidemiology
School of Public Health
University of California, Berkeley
2121 Berkeley Way, #5302
Berkeley, California 94720-7360
Phone: [redacted]
Fax:
E-mail:

DATE OF BIRTH: October 31, 1948

PLACE OF BIRTH: Chicago, Illinois

MARITAL STATUS: Married

EDUCATION:

1966 - 70	A.B.	University of Chicago
1970 - 76	M.D.	University of Chicago

POSTGRADUATE TRAINING:

1976 - 78	Internal Medicine Resident, Mount Auburn Hospital Cambridge, Massachusetts
1980 - 82	Preventive Medicine Resident, Centers for Disease Control (CDC) - Atlanta, Georgia

POSITIONS HELD:

1979 - 80	Epidemic Intelligence Service Officer, State of Connecticut - Department of Health Services Hartford, Connecticut
1980 - 81	Epidemic Intelligence Service Officer, Special Pathogens Branch - Bacterial Diseases Division Centers for Disease Control (CDC) - Atlanta, Georgia
1981 - 85	Assistant Chief, Respiratory & Special Pathogens Epidemiology Branch, Center for Infectious Diseases Centers for Disease Control (CDC) - Atlanta, Georgia
1985 - 87	CDC Liaison Officer, Office of the Director Centers for Disease Control - Atlanta, Georgia

FACULTY APPOINTMENTS:

1979 - 80	Instructor, Department of Medicine (Epidemiology) University of Connecticut - Hartford, Connecticut
1985 - 87	Visiting Lecturer, Department of Biomedical and Environmental Health Sciences (Epidemiology) University of California, Berkeley
1987 -	Professor of Epidemiology, School of Public Health, University of California, Berkeley
1989 -	Professor, Department of Epidemiology and Biostatistics - University of California, San Francisco

Arthur Lawrence Reingold

FACULTY APPOINTMENTS (CONTINUED)	1990 - 94	Head, Epidemiology Program, Department of Biomedical and Environmental Health Sciences, University of California, Berkeley
	1991 -	Clinical Professor, Department of Medicine University of California, San Francisco
	1994 - 2000	Head, Division of Public Health Biology and Epidemiology University of California, Berkeley
	2000 - 2018	Head, Division of Epidemiology, School of Public Health, University of California, Berkeley
	2018 -	Head, Division of Epidemiology and Biostatistics, School of Public Health University of California, Berkeley
	2008 - 2014	Associate Dean for Research, School of Public Health, University of California, Berkeley
	2009 - 2014	Edward Penhoet Distinguished Chair for Global Health and Infectious Disease
MEDICAL LICENSURE:		California
BOARD CERTIFICATION:	1980	American Board of Internal Medicine
AWARDS:	1970 - 74	Medical Scientist Training Program
	1985	Commendation Medal, U.S. Public Health Service
	1986	Charles Shepard Award, Centers for Disease Control (CDC)
MEMBERSHIPS:	1970	Sigma Xi
	1978	American College of Physicians
	1983	American Society for Microbiology
	1984	Society for Epidemiologic Research
	1986	Infectious Disease Society of America (Fellow)
	1988	American Epidemiological Society
	1991	American College of Epidemiology (Fellow)
	1994	AAAS (Fellow)
	2003	Institute of Medicine, National Academy of Medicine (Member)

PROFESSIONAL ACTIVITIES

CONSULTATIONS:	1981	Institute of Medicine: Toxic-shock syndrome
	1981	Food and Drug Administration: Toxic-shock syndrome
	1982	United States Agency for International Development: Control of meningococcal meningitis in West Africa
	1983	World Health Organization (WHO): Control of meningococcal meningitis in Nepal
	1983	East-West Center, University of Hawaii: Role of indoor air pollution in acute respiratory infections in developing countries
	1984	Institute of Medicine: Meningococcal vaccines

Arthur Lawrence Reingold

CONSULTATIONS (CONTINUED)	1986	World Health Organization (WHO): Control of meningococcal meningitis in South Asia
	1987 - 1993	Center for Child Survival, University of Indonesia: Control of Acute Respiratory Infections
	1988	Evaluation of the Combating Communicable Childhood Disease Program, Ivory Coast
	1994	Evaluation of National Epidemiology Board Program, Rockefeller Foundation
	1995	Planning of a School-based Acute Rheumatic Fever Prevention Project - New Zealand Heart Foundation
	1995	Vaccines Advisory Committee, Food & Drug Administration Approval of accellular pertussis vaccine
	1996	External Reviewer, NIAID Group B Streptococcus Research Contract with Harvard University
	1996 - 2000	U.S. Food and Drug Administration; Consultant to the Vaccines Advisory Committee
	1996	World Health Organization, Consultation on Control of Meningococcal Meningitis in Africa
	1998 – 2002	Advisor to the INCLEN "Indiaclen" project
	2002 – 2003	Evaluation of a School-based Acute Rheumatic Fever Prevention Project – New Zealand Heart Association
ADVISORY BOARDS AND PANELS:	1988 - 1989	Member, Advisory Committee on Ground Water and Reproductive Outcomes, State of California Department of Health Services
	1989 - 1990	AIDS Advisory Committee, Alameda County Board of Supervisors
	1989 - 1993	Advisory Committee, Birth Defects Monitoring Program, State of California Department of Health Services
	1993 - 1995	Centers for Disease Control (CDC): Public Health Service Advisory Panel on the Case Definition for Lyme Disease
	1992 - 1994	World Health Organization (WHO): Task Force on Strengthening Epidemiologic Capacity; Childhood Vaccine Initiative
	1996 - 2000	Armed Forces Epidemiological Board
	1997 - 2012	University of California, San Francisco AIDS Research Institute Steering Committee
	1998 - 2003	Emerging Infections Committee of the Infectious Diseases Society of America
	1998 – 2000	Panelist, Howard Hughes Medical Institute Predoctoral Fellowship
	2001 - 2006	Technical expert, Sub-Committee on the Protection of Public Health; California State Strategic Committee on Terrorism

Arthur Lawrence Reingold

ADVISORY BOARDS PANELS (CONTINUED)	2003 - 2008	Advisory Board, Chinese University of Hong Kong – Centre for Emerging AND Infectious Diseases
	2004 -	Advisory Board, University of California, Berkeley Clinical Research Center
	2004 - 2008	Advisory Board, New York University School of Medicine Fellowship in Medicine and Public Health Research
	2004 - 2005	Institute of Medicine Committee on Measures to Enhance the Effectiveness of CDC Quarantine Station Plan for U.S. Ports of Entry
	2005 - 2012	Strategic Advisory Group of Experts (SAGE) for Vaccine Policy, World Health Organization (WHO) (Deputy Chairman, 2010-2012)
	2005 -	Data and Safety Monitoring Committee; F.I. Proctor Foundation, University of California, San Francisco (UCSF)
	2007 - 2012	NIH Fogarty International Center External Advisory Board
	2007 - 2009	Chair, Working Group on Pneumococcal Vaccine, Strategic Advisory Group of Experts (SAGE), World Health Organization (WHO)
	2008 - 2012	Working Group on H5N1 Influenza Vaccines, Strategic Advisory Group of Experts (SAGE), World Health Organization (WHO)
	2008 - 2011	Chair, Leptospirosis Burden Epidemiology Reference Group, World Health Organization (WHO)
	2008 - 2012	National Biosurveillance Advisory Subcommittee of the Advisory Committee to The Director, Centers for Disease Control and Prevention (CDC)
	2008 - 2009	Institute of Medicine Committee on the Review of Priorities in the National Vaccine Plan
	2009 - 2012	Chair, Working Group on Hepatitis A Vaccine, Strategic Advisory Group of Experts (SAGE), World Health Organization (WHO)
	2011 - 2013	Member, Institute of Medicine Committee on Vaccine Priorities
	2011 - 2014	Member, Working Group on Vaccine Hesitancy, Strategic Advisory Group of Experts (SAGE), World Health Organization (WHO)
	2012 - 2014	Chair, Review of the Heterologous Effects of Childhood Vaccines, World Health Organization (WHO)
	2012 - 2014	Chair, External Review of the Measles Rubella Initiative (of WHO, CDC, UNICEF, American Red Cross, and United Nations Foundation)
	2013 - 2018	Advisory Committee on Immunization Practices (ACIP), U.S. Department of Health and Human Services
	2016 - 2017	Member, Institute of Medicine Committee on a National Strategy for the Elimination of Hepatitis B and C
	2018 - 2019	Member, Independent Review Committee, Global Alliance for Vaccines and Immunizations (GAVI)

Arthur Lawrence Reingold

ADVISORY BOARDS PANELS (CONTINUED)	2018 -	Member, Strategic Advisory Group, Partnership for Influenza Vaccination Introduction
	2020	Member, Organizing Committee, National Academics of Science, Engineering, and Medicine (NASEM) Workshop on Airborne Transmission of SARS-CoV-2
	2020	Member, National Academies of Science, Engineering, and Medicine (NASEM) Committee on Equitable Allocation of Vaccines for the Novel Coronavirus

LEADERSHIP POSITIONS:

1997 - 2012	Secretary-Treasurer, American Epidemiological Society
2009 - 2010	President, Society for Epidemiologic Research
2015 – 2016	President, American Epidemiological Society (AES)

EDITORIAL BOARDS:

1995 - 2000	Board of Editors, American Journal of Epidemiology
2001 - 2005	Board of Editors, Epidemiology
2005 -	Editorial Advisory Board, Global Public Health
2009 - 2010	Editorial Advisory Board, American Journal of Epidemiology

ASSOCIATE EDITORSHIPS:

2017 - 2019	Current Epidemiology Reports
2018 -	Vaccine

Arthur Lawrence Reingold

PUBLICATIONS:

1. Hayes RV, Pottenger LA, Reingold AL, Getz GS, Wissler RW. Degradation of I^{125} - labeled serum low density lipoprotein in normal and estrogen-treated male rats. Biochem Biophys Res Comm 1971;44:1471-1477.

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